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REPORT OF THE SUBCOMMITTEE ON
INSTITUTIONAL PROGRAM GUIDELINES

GUIDELINES FOR ESTABLISHING
STANDARDS FOR:

ASSESSMENT AND PLACEMENT FOR ADULT LONG-TERM CARE: A SINGLE-ENTRY MODEL

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un modèle à accès unique

NOTE

The information contained in these guidelines is considered current as of the date of their approval; however, since many aspects of health care and health technology are constantly changing, we welcome any suggested amendments. Information on new developments or related issues should be directed to:

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Further copies of these guidelines in either English or French can be obtained from the above address.

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PREFACE

Technological advancement and changes in the delivery of health care services have led to the need for guidelines to assist in planning and implementing institutional programs and services. The guidelines that follow represent one of a series of publications produced under the direction of the Subcommittee on Institutional Program Guidelines. They provide a consistent definition of the requirements for a number of special care units, services and programs in health institutions (hereafter in the introduction referred to as services).

In general, guidelines are based on information, knowledge, experience, research and expert opinion from health professionals and organizations throughout Canada. This method alows many Canadians from across the country to contribute to the guidelines, hence a consensus on the suggested approach can be achieved. Additional material is often obtained from national and international health organizations and from other experts knowledgeable in the subject matter.

Background

Under the direction of the Federal/Provincial Advisory Committee on Institutional and Medical Services, the guidelines program has been in operation since 1972. A standing Subcommittee of the Advisory Committee, the Subcommittee on Institutional Program Guidelines, composed of federal and provincial government and professional representatives, coordinates the development of the guidelines commissioned by the Advisory Committee.

The guidelines are produced by the expert working groups of health professionals, some of whom are government representatives. The final draft is reviewed and recommended by the Subcommittee for approval by the Advisory Committee.

Purpose

The purpose of the guidelines is to provide a comprehensive outline of requirements for services in health institutions. While a consensus of expert knowledge and experience is reflected in the guidelines, these should not be regarded as rigid standards. Provincial health authorities may modify the application of the guidelines to meet their needs.

Where development of a service is being contemplated, we believe the guidelines will be of help in determining the need for such a service, either locally, regionally or in some cases provincially or interprovincially.

Established services may take advantage of the guidelines in screening deficiencies and solving problems without having to develop new services. Where a service already exists, the guidelines will help:

- to identify problems related to administration, personnel, equipment and facilities,
- to determine necessary remedial action,
- to set priorities for corrective measures on the basis of clinical need, funding and the degree to which the service is deficient.

Future

The dramatic increase in the number of intensive and special care services in health institutions has given rise to the need for additional facilities, specialized equipment and highly trained personnel. At the same time, new approaches to patient care have evolved. These emphasize the need for a continuum of care in which admission to an institution is only one aspect of total care. Therefore, linkages along the health care continuum, ranging from illness prevention to chronic care, must be identified. As new treatments and procedures are put into practice, there will be a continuing need for guidelines to assist those involved in the planning and operation of institutional services.

Revisions

Due to the rapidly changing nature of health care delivery, guidelines will need updating and revision. The Subcommittee on Institutional Program Guidelines plans and oversees these revisions.

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PREAMBLE

Improvements in public health practices, new technological advances and a better understanding of the preventive, curative, social and rehabilitative aspects of health care have resulted in increased survival for persons suffering from a wide variety of chronic illnesses and disabilities. Consequently, there has been an increase in the number of Canadians of all ages who require some form of long-term care.[1]

For most communities in Canada, long-term care comprises a range of community and institution-based services to meet the needs of persons requiring assistance with activities of daily living. Effective assessment and placement for appropriate services has become a priority issue for most communities.[2]

The purpose of the guidelines that follow is to help planners and health authorities to develop and enhance their service delivery systems. The guidelines were developed within the context of a single-entry model which is in place in some provinces. This model provides for entry to a wide range of community and institution-based services from a single coordinator point for assessment and placement in the health care system.

While the guidelines recommend the single-entry model which can accommodate a variety of system variations, it is clearly the prerogative of each province to accept, modify or reject this approach according to provincial priorities or uniqueness. However, whatever system is used, the process of

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[1] See: Population to Be Served, pages 9 to 12.

[2] As identified in guidelines for Adult Long Term Institutional Care, Health Services Directorate, Department of National Health and Welfare, 1984, pp. 7-11.

assessment and placement should be comprehensive and coordinated to avoid gaps, duplication and delays in service delivery.

Long-term Care

"Long-term care represents a range of services that address the health, social and personal care needs of individuals who, for one reason or another, have never developed or have lost some capacity for self-care. Services may be continuous or intermittent, but it is generally presumed that they will be delivered for the 'long term' that is, indefinitely to individuals who have demonstrated need, usually by some index of functional incapacity."[3]

Based on this concept of long-term care, health authorities must specify their target population and devise a range of program initiatives. The continuum of long-term care services[4] must interrelate with other components in the spectrum of health care. Relationships must be defined with acute care services, physician services, rehabilitative services, preventive programs and community services including mental health, alcohol and drug treatment services and housing or shelter programs.

Assessment and Placement

Assessment and placement play a key role in the delivery of long-term care. Within the context of this document, assessment and placement include a number of tasks (see Diagram II):

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[3] Definition used by the Federal/Provincial/ Territorial Subcommittee on Long-Term Care.

[4] See section 6.3 and Appendix II "Continuum of Long-Term Care Services".

- screening applicants to determine their needs, the urgency of the situation, eligibility for services, and to respond to requests for information only;

- assigning a case coordinator to assess the nature of the person's health-related problems;

- scheduling an assessment (urgent, routine, specialized, etc.);

- assessing problems, supports and service needs;

- activating treatment of remediable conditions;

- establishing a service plan in conjunction with the client, the family and other personal supports and service providers;

- implementing the service plan;

- monitoring client needs and modifying the care plan as necessary;

- adjusting service delivery when required to meet ongoing needs.

Assessment is the collection and collation of information required to understand the person's need for assistance.

Case coordination is a major function in the assessment and placement process noted above and spans all of the tasks outlined.

Placement is the function which matches available services to the person's needs and facilitates access to these services. The term "placement" has traditionally been used to describe admission to institutional care.

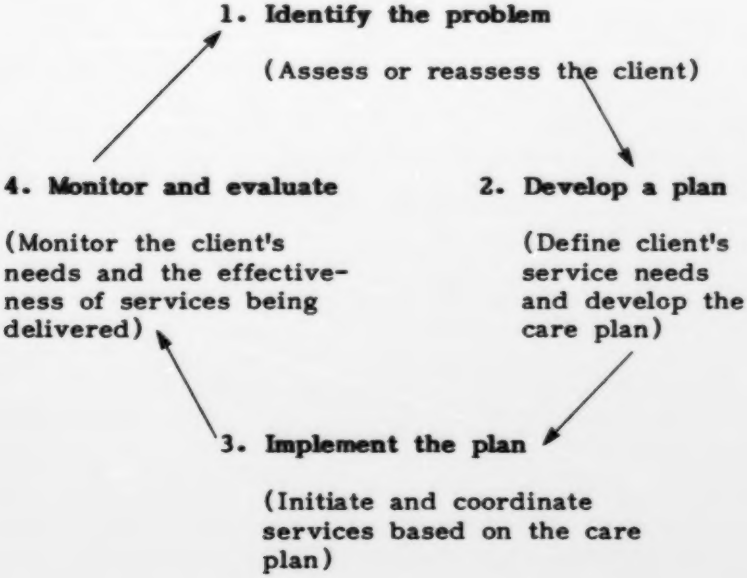
In this model and throughout the document, "placement" is used to describe accessing the full range of community-based services (including home care) and facility-based care and includes

implementation of the service plan and monitoring the client's progress.

It is helpful to see the assessment and placement process as a dynamic activity. In Diagram I, a simplified version of the problem-solving approach is applied to assessment and placement activities.

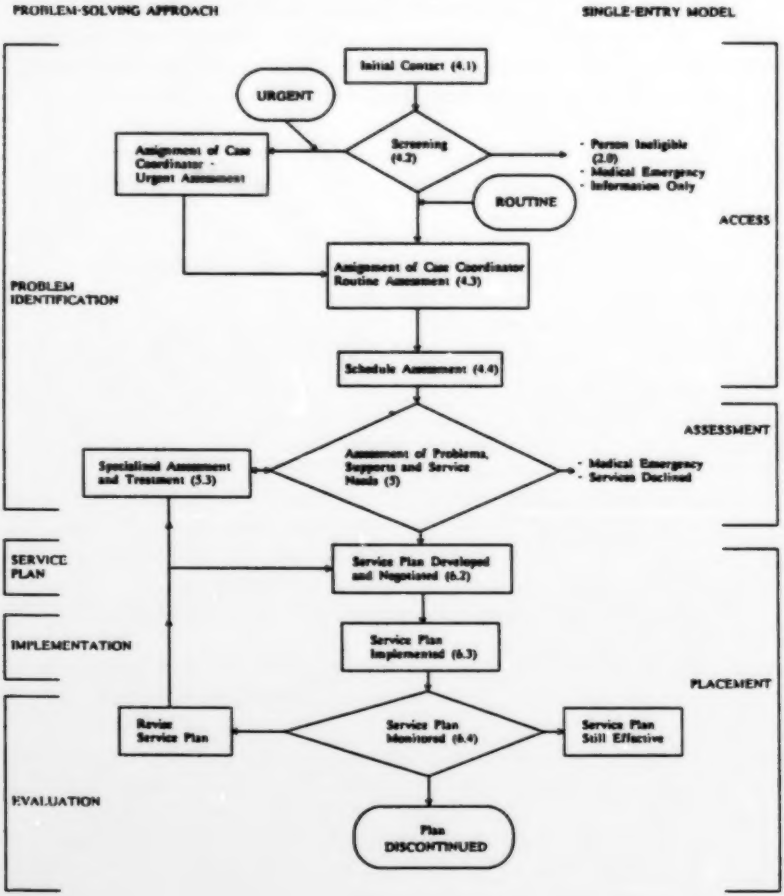
Diagram I

Application of the problem-solving approach to assessment and placement activities


1. Identify the problem
(Assess or reassess the client)
2. Develop a plan
(Define client's service needs and develop the care plan)
3. Implement the plan
(Initiate and coordinate services based on the care plan)
4. Monitor and evaluate
(Monitor the client's needs and the effectiveness of services being delivered)

In Diagram II the single-entry model for the process of assessment and placement outlined on page 3 is shown in the form of a flow chart with reference to the various stages of the problem-solving approach.

DIAGRAM II
PROBLEM-SOLVING APPROACH



The numbers on the flowchart correspond with the guideline section that spells out the process in detail.

PRINCIPLES

Assessment and placement processes are dynamic and the placement variables are interdependent, continuously requiring modification and appropriate adjustment of assessment procedures.

The following principles underlie the assessment and placement and influence the development of long-term care assessment and placement systems.

1. Assessment and placement is an integral part of the long-term care system.

2. Health promotion and disease prevention are an essential part of the assessment and placement process.[5]

3. Assessment and placement takes place in a timely fashion with the capacity to respond to emergencies.

4. Assessment and placement allows for family referral and self-referral.

5. Assessment and placement is a process that respects each person as an individual.

6. Assessment and placement assists individuals to optimize their level of functioning.

7. The individual is involved in and to the degree possible has control or choice over assessment and placement decisions. The family is involved in the same way if the individual so desires or in cases where the individual is declared incompetent.

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[5] As recommended in Achieving Health for All: A Framework for Health Promotion, Department of National Health and Welfare, 1986.

8. Assessment and placement ensures that service is provided at a level consistent with the individual's needs.

9. The individual's physician and other caregivers are consulted during assessment and placement.

10. Whenever feasible assessment is carried out in the person's usual place of residence.

11. Assessment and placement provides access to a range of professional expertise.

12. The assessment and placement process allows for evaluation of its components.

Benefits

Assessment and placement has the following benefits:

- The full range of community and facility options are considered for each individual.

- Remediable conditions are identified and treated.

- Access to services is controlled through the consistent application of priorities and eligibility criteria.

- Individuals are appropriately referred to services based on their level of need, thereby reducing the risk of under-servicing or over-servicing.

- Inappropriate institutional placement is avoided.

- Because the single-entry model provides for a single assessment, duplication of professional effort is avoided, as is the associated stress on the client and family (traditionally a person received a separate assessment for each service that he/she required).

GUIDELINES

1. POPULATION TO BE SERVED

1.1 Persons (15 to 64 Years of Age) with Physical and Mental Disabilities

In Canada approximately 15 per cent of all adults receiving long-term care in the community are between 15 and 64 years old.[6] In Residential Care Facilities, approximately 23 per cent of the residents are aged between 18 and 64 years.[7]

Adult persons under 65 years of age who require long-term care have a variety of disabilities that are a result of congenital disabilities, mental illnesses such as chronic schizophrenia, physical illnesses such as multiple sclerosis and organic injury and trauma that cause conditions such as cerebrovascular accidents and quadriplegia.

Because the numbers of younger persons receiving long-term care are small in comparison to the elderly, special consideration must be given to planning and programming for the age group 15 to 64 years. Developmental needs, goal expectations and life expectations must be planned for. Each person must have appropriate opportunities for socialization of a similar age. The problems that younger disabled persons experience in expressing

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[6] Profile of Disabled Persons in Canada, Social Trends Analysis Directorate, Department of the Secretary of State, November 1986.

[7] Unpublished data, Statistics Canada, 1986. (Of the persons 18 to 64 years who represent 23 per cent of total beds, the major categories are as follows: five per cent are classified as aged, six per cent as mentally retarded, seven per cent as mentally handicapped, two per cent with alcohol and drug-related problems, and one per cent as physically handicapped.)

their sexuality and other personal needs must be acknowledged and counselling should be available for these persons, staff and family/friends where appropriate. Special planning will also be needed for dealing with behavioural problems that occur more frequently and are more difficult to handle than in the elderly age group.

Specialized education, rehabilitation therapy and job opportunity programs will be required. Many of these activities will require extra financial support.

1.2 Persons (65 Years of Age and Older)

Persons 65 years of age and older, and particularly the very old, represent the largest group requiring long-term care, and it is this age group which is growing most rapidly in our population. In 1987 one in every ten Canadians was over 65 years of age. It is projected that this rate will increase to one in seven by the year 2001 and one in five by 2021. While the majority of elderly Canadians will be able to live in their communities without additional support, it is predictable that due to increases in the absolute numbers of elderly, especially in the old-elderly age group, (over 85 years of age), there will be an increase in demand for long-term care services.

1.3 Mentally Dysfunctioning Elderly

The rate of psychiatric disorders increases with advancing age and is particularly high among the elderly living in institutions. This increasing rate can be explained by the high prevalence of organic mental disorder in old age, the close association

between chronic physical disability and psychiatric symptoms, the increased use and effects of various drugs, and psychosocial stress.[8]

The most common psychiatric disorders are depression and dementia. Distinguishing between the two conditions can be difficult since depression can present with memory impairment (pseudo dementia). Also the symptoms of depression can be entirely atypical. Instead of expressing feelings of sadness, worthlessness or guilt, the older person may complain of anxiety or bodily discomfort. Suicidal intentions may be present but are often not mentioned.[9]

Dementia has various causes but the most common is Alzheimer's disease. Patients suspected of dementia must undergo a comprehensive medical assessment to identify the correct underlying reasons. Alzheimer's disease is characterized by its typical clinical history and by the exclusion of other identifiable diseases which are known to cause symptoms of dementia.

Paranoid symptoms are often secondary to memory loss. However, they can also be caused by sensory impairment (particularly hearing loss), alcohol abuse and increasing social withdrawal and isolation. Depression can also cause the elderly to become suspicious. Paranoia and late onset schizophrenia are less frequent causes for paranoid behaviour.

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[8] The elderly have to face profound changes which require adaptation to their decline in social and economic status, loss of spouse and close friends, diminished trouble-free health and increasing isolation.

[9] Report of the National Task Force on Suicide in Canada, 1987 Mental Health Division, Health Services and Promotion Branch, Health and Welfare Canada.

Acute psychiatric symptoms are most commonly caused by delirium (acute confusional states). If the underlying illness is not identified and treated, mortality due to this disorder is high.

2. ELIGIBILITY CRITERIA

As health systems and communities differ across Canada, each jurisdiction must clearly define the population or clientele that will require long-term care services. Generally, eligibility criteria relate to age, duration of residence in the province and the existence of one or more conditions which require care to be provided over an extended period. The criteria should differentiate those individuals whose conditions are still acute or require extensive rehabilitative services.

Some health jurisdictions establish a classification system to differentiate their long-term care clientele according to functional status and service needs.

As well, some health jurisdictions levy an income-related user charge on supportive social/health services. In such cases, the assessment and placement process includes an income test to establish the client's subsidy level.

3. THE SINGLE-ENTRY MODEL

The single-entry assessment and placement system is characterized by three features:

1. Access to the long-term care system is provided through a single administrative structure.

2. Standardized methodology is used to identify needs, and to plan and initiate service.

3. A professional undertakes the case coordination function for each individual in order to ensure a systematic approach to service delivery and to facilitate communication.

The pre-condition for implementation of a single-entry model of assessment and placement is agreement between the assessing authority and the service providers in a given area that a standardized assessment constitutes the authority for admission into their services. This agreement can only be effective if it is formal in nature e.g. part of a regional health program or regulated by health legislation. This allows assessment and placement personnel the authority to act objectively in the best interest of the client.[10] The agreement also requires waiting list policies that ensure consistent, equitable access to long-term institutional facilities on a planned or emergency basis. Formal mechanisms to facilitate information exchange are necessary. The assessment and placement service must have up-to-date information on existing services in the community. Similarly, community agencies must be informed of the philosophy, policies and client population of the long-term care system in order to make appropriate referrals.

It is recommended that, in order to facilitate this information exchange, a mechanism such as a community advisory committee meet on a regular basis. All community agencies concerned with providing long-term care will have to work together to facilitate this information exchange. In general, information will be required about:

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10 It is important to note that the assessment and placement agency does not need to have authority over the range and volume of services available in the area. From their unique position in the system however, case coordinators and other members of the assessment and placement service are able to identify gaps in service, service volume difficulties and innovative alternatives in the continuum of care.

- defined client groups

- available existing services:
  - range of services provided

  - service policies e.g. coverage outside of the specific geographic area served

  - phone numbers and addresses

- gaps in service

- emergency coverage

3.1 Assessment and Placement within the Single-entry Model

The assessment and placement process has a number of steps. In the single-entry model, these steps have a significant order (as depicted in Diagram II) and are categorized into the following three major phases (these phases are described in more detail later in the document):

3.1.1 Access to the single-entry model

. Initial contact

. Screening

. Assignment of a case coordinator

. Scheduling of an assessment visit

In this phase, the screening process provides an opportunity to refer the person requesting service to a health practitioner, community agency or other relevant resource when the person is ineligible for long-term care services or requires information on other available community services. The process also includes an urgent response capability whereby the assessment scheduling procedure is initiated immediately.

3.1.2 Assessment

- Problem identification
- Identification of personal, family and community support systems
- Service needs identification

This phase includes the option of halting action where the individual is found to be ineligible for long-term care services, or declines services. If urgent medical care is required, the person is referred to appropriate sources. Where an in-depth analysis of the individual's medical and physical problems is required, referral to specialized assessment and/or treatment services is undertaken. These phases of access and assessment coincide with the Problem Identification step of the problem-solving process (Diagram I).

3.1.3 Placement

- Development of a service plan with the client
- Implementation of the plan
- Monitoring of the effectiveness of the plan

This phase provides for negotiation with the individual and/or the family of the service plan, often with short- and long-range goals, and for a variety of actions during the monitoring process. At each review point, a decision will be made on the effectiveness of the care plan. If the plan continues to meet the needs of the client, services will remain unchanged and a new review date will be established. Where the plan no longer meets the needs of the client, service levels will be adjusted or a re-assessment will be undertaken to establish a revised care plan. Where services are no longer required, the plan will be discontinued.

This phase coincides with the steps of: **Develop a Plan, Implement the Plan, and Monitor and Evaluate the Plan,** as defined in the problem-solving process (Diagram I).

3.2 Case Coordination

Case Coordination is a pivotal concept in the single-entry model. It is the essential means for assuring that clients' needs are assessed and that appropriate services are identified, implemented and monitored. Case coordination also benefits the delivery system. By coordinating and evaluating serivces, treatment is more effective and services are less likely to be duplicated.

The case coordinator also functions as the ongoing primary contact for the client, the family and the service providers, and is responsible for coordinating assessment and monitoring functions related to the client. Specifically, the case coordinator:

- relates to clients on an individual basis
- initiates the assessment
- integrates assessment data into a single comprehensive summary/record
- develops the service plan in conjunction with the client, the family, the client's general practitioner and service providers and other professionals as required
- requisitions services
- monitors service delivery

3.2.1 Staffing Ratio

As case coordination is a relatively new concept and has only been recently developed in some parts of Canada, appropriate staffing ratios are under development and it is expected that, with further study, guidelines will be set. However, it is important to

note that the functions of case coordination can only be carried out effectively if the caseload is of a reasonable size. Therefore, a workload index should be introduced and should establish caseloads based on the specific tasks and duties assigned to the case coordinator within the particular jurisdiction. As well, workload index should take into consideration rural and urban influences.

3.2.2 Qualifications

In selecting case coordinators, it is important to choose staff with the requisite knowledge and skills. A case coordinator requires a broad base of knowledge, skills and understanding in the following areas:

- the role of the various disciplines involved in the assessment/placement process
- the treatment and management of chronic illness
- normal aging processes
- the use of medication (prescription and over-the-counter)
- rehabilitation
- community resources (knowledge of eligibility criteria, regulations, policies and details of the services available from public and private community agencies, financial assistance, social services, housing)
- society's attitudes towards the disabled and the elderly
- human rights and protection under the legal system
- anticipation, prevention and effective management of crisis situations

In addition to this specific knowledge, the case coordinator must be able to work creatively and independently, take initiative, and demonstrate effective communication skills. The position requires an ability to work in situations demanding interdisciplinary communication and cooperation, a systematic approach to observing and interviewing, assessment skills, creative problem-solving skills, and a sensitivity to clients' needs and wishes.

Since an interdisciplinary approach is advocated, it is expected that case coordinators will be selected from a variety of professional disciplines including nursing, social work, physiotherapy and occupational therapy.

3.2.3 Staff development .

Case coordination is highly demanding and stressful. Continuing education and training opportunities must be made available.

4. ACCESS TO THE SINGLE-ENTRY SYSTEM

4.1 Initial Contact

Initial contact with the long-term care system may be made by telephone or in person by the individual requesting assistance or by a relative, friend or professional acting on the person's behalf. This may happen for persons in the community, in acute care hospitals or in other institutional care settings. How and where referrals are received will depend on the organization of the system. For example, in an urban setting, there may be a central office with an intake worker taking referrals; in a small rural community, there may be an arrangement with the local health office where a caller can leave a message requesting a call back.

Mechanisms should be estalbished to facilitate access to the long-term care system from the acute care hospital when continuing care is required. Referrals from hospitals should be initiated as early as possible so that assessment can be undertaken in a timely

manner, the range of long-term care options can be considered, and a service plan is in place at the time of discharge. This can be accomplished through cooperation and communication with staff that are using the hospital's discharge planning process.

4.2 Screening

The intake function can be assigned to an individual health professional or may be shared by case coordinators. On initial contact, the intake worker gathers the following information:

- identifying data
- the degree of urgency
- the caller's description of the problem and perceived need
- eligibility data

This information allows the intake worker the following courses of action:

- provision of information only
- referral to an appropriate service within the system but outside of placement options e.g. Alzheimer's Society Support Group
- referral for crisis situations not dealt with by the long-term care system e.g. acute medical emergency
- assignment of a case coordinator for urgent/ priority assessment
- assignment of a case coordinator for routine assessment

4.3 Selection of the Case Coordinator

Case coordinators can be assigned on a rotational basis or the assignment can be based on:

- the characteristics of the client
- geographic location
- qualifications of the case coordinator

4.4 Scheduling of Assessment

It is very important to have an emergency assessment capability. When the case is deemed to be urgent, the case coordinator will be assigned immediately to ensure that the assessment will proceed as quickly as required. In a routine case, the case coordinator receives the information gathered in the screening process and schedules the initial assessment visit. The single-entry system should have response time guidelines that are appropriate and realistic. Clients should be informed of the time frame in which a response to their call will be made and the case coordinator will schedule the visit accordingly.

4.5 Location/Setting of Assessment

Assessment of the client and his/her support network should be carried out in the person's usual place of residence. When a client is in hospital, it is important that he/she be stabilized prior to placement and that subsequent to discharge, a follow-up assessment be undertaken in his/her home setting. Following a recuperation period, service must often be adjusted to reflect a change in level of functioning.

Assessing the client in the usual place of residence minimizes stress for him/her because of the familiar surroundings and allows for:

- observation of behaviour in normal surroundings
- assessment of the home environment
- observation of interaction with family and relevant others

4.6 Awareness and Knowledge of the System

In order to ensure timely and appropriate referral, provision should be made to educate and inform the public; local health services including acute hospital emergency out-patient departments; family physicians, public health nurses, social service practi-

tioners; community-group leaders; industry representatives; senior citizens groups; operators of senior housing and special interest groups.

Special strategies that can be developed to make a single-entry system known to these groups include:

- regular articles in professional and local publications - journals, periodicals, newspapers, leaflets, radio as well as television

- separate prominent listings of the system's phone numbers and addresses in the telephone directory

- information pamphlets to relevant professional groups, community groups and community bulletin boards

- use of the regular communication channels of local professional associations to inform their members

- use of direct mail to inform health practitioners, health institutions and public health nurses.

5. ASSESSMENT IN THE SINGLE-ENTRY SYSTEM

5.1 Introduction

In the assessment process, data is collected to: define problems, identify service needs; and, identify personal family and community support systems. Using a standardized approach, a core of informaton is collected. The case coordinator decides on the extent of the assessment process required in each case.

Case coordinators come from a variety of professional backgrounds and, if necessary, the case coordinator will consult with other health professionals as required as part of the assessment process, especially seeking input from areas serving the special needs of the client. In cases which are complex, a formal multidisciplinary team assessment may be warranted in assessing the needs of the client. Some medically complex cases may exceed the skills

and investigative capability of the community assessment resources. In such cases and where service is available, the case coordinator would be expected to arrange for referral of the client for specialized assessment.

5.2 Collection of Information

The case coordinator must collect information from a variety of sources. A clinical history of the client must be obtained. The client's physician will be expected to provide necessary medical information. A standardized assessment form must be completed; a number of standardized assessment forms have been developed and will lead the case coordinator through a structured assessment procedure and form the basis of a health care record for each client.[11] Information will also be obtained from other sources including previous caregivers and the client's family. The coordinator may consult with other case coordinators, professional colleagues and/or hold a case conference with other professionals.

Assessment forms record the measurement of physical, mental and social levels of functioning. The results from assessment instruments can provide objective measures on which to establish the categorization and care needs of the clients. However, the identification of remedial conditions and the requirement for further assessment and/or treatment can only be obtained from clinical interview data, case conferences and consultations with other professionals including the client's family physician. Where recent medical information is not available, the client should be encouraged or required to seek a consultation/examination.

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11 Appendix I contains an example of such information. Because the record is standardized, it can be centrally maintained, computerized as appropriate and is readily available to be shared and updated by all team members involved in the case.

5.3 Specialized Assessment[12]

While it is recognized that the majority of assessments can be handled by the community assessment staff, the need for additional specialized assessment, medical, psychiatric, etc. may be identified. Arrangement for appropriate referral is the responsibility of the case coordinator with consultation as required.

5.4 Identification of Service Needs

Once a thorough assessment of the client's problem(s) has been completed, including specialized assessment as required, and all remediable conditions have been identified, the case coordinator will arrive at a statement of the client's service needs. It is recognized that interim services may be required during the assessment process and before the service plan is completed.

6. PLACEMENT

6.1 Introduction

Placement refers to the task of matching appropriate and available services to the assessed service needs of the individual. The placement phase also includes implementation of the service plan and monitoring the person's progress as long as the person remains a client of long-term care. In creating the service plan, the case coordinator selects from services available in the community. Ideally, a continuum of services will be available in the local area; however, in some cases, special arrangements will have to be made to use services from other areas.

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12 See also Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders, "Chapter I, The Assessment Process", Mental Health Division, Health Services Directorate, Department of National Health and Welfare, 1988.

6.2 Developing and Negotiating the Service Plan

The service plan will build on the strengths of the person and on his/her personal, family and community support.

Planned interventions will be developed in relation to identified problems and will be based on the concept of maintaining or restoring the highest degree of independent functioning possible.

In general, case coordinators and other participants in the assessment and placement process must encourage clients to take responsibility for themselves so that over-servicing does not occur. This is sometimes a difficult task, especially when individuals feel that they have a "right" to public services.

Clients who refuse services that could have a supportive and preventive effect will require follow-up, information and encouragement in order to make an informed choice. The right of the client to live "at risk" must always be respected.

The case coordinator selects from available services those which most closely meet the care needs and wishes of the client.[13] The service plan identifies specific interventions and establishes short- and long-term goals.

The service plan is then reviewed with the client and his/her support system(s). If the plan is acceptable, the designated services are requisitioned. Where there are differences in a client's expectation for service, the case coordinator must negotiate the most acceptable arrangement for service according to provincial legislation. An appeal process must be built into the system to review dissension, accommodate clients/families, the client's family physician/clergy, etc. who are not satisfied with the

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13 For examples of services providing a continuum of care, see Appendix II.

proposals for service. This is especially important when major changes must be made in the client's life, e.g. moving to assisted housing or an institutional setting.

6.3 Implementing the Service Plan

In initiating service, the case coordinator will pass relevant information on to the service provider(s). Information will be relevant. Policies will need to be developed with respect to the safekeeping of records and the release of information that may be sensitive and confidential.

6.4 Monitoring the Service Plan

It is the responsibility of the case coordinator to monitor the service plan for each individual to ensure that services received are consistent with the goals of the service plan. The client's functioning and his/her support system(s) must be monitored to determine the effectiveness of the service plan. Review dates are established by the case coordinator. Depending on the outcome of the evaluation, the plan will be continued, revised or discontinued. If the plan is discontinued, the client must be referred back to his/her family physician.

Responsibility for monitoring the service plan may change (e.g. if the person is transferred to a facility, the case coordinator function may be assumed by a facility employee). Monitoring the effectiveness of the plan is essential for ensuring continuity of care.

SAMPLE BASIC ASSESSMENT DATA

NAME
SOCIAL OR HEALTH IDENTIFICATION NUMBERS (as required in jurisdiction)
ADDRESS AND (CONTACT) TELEPHONE NUMBERS

SOCIAL HISTORY

Sex, date of birth

Family - original family members, current family members

Religion

Marital status

Family doctor - name and address

Employment - current, or if retired, previous interests

Length of time at current location

Current family or friend support

Current formal support, e.g. visiting nurse

Sources of income (where applicable)

Language spoken - language of choice

Other person who can give additional information

Name of assessor

Date

ACTIVITIES OF DAILY LIVING

Eating

Bathing and grooming

Dressing

Elimination - bowel and bladder

SOCIAL/COMMUNITY ACTIVITIES

Shopping

Cooking

Housekeeping/House maintenance - light - heavy

Social interactions

COMMUNICATION SKILLS

Reading

Speech

Hearing

Vision

Writing

MOBILITY SKILLS

Transfers (bed to chair)

Ambulation

Stair climbing

CURRENT LIVING ENVIRONMENT

Own home

Shared lodging

Institution

Physical barriers

Size of personal living space in daily use

NUTRITION

Likes/dislikes

Diet restriction

Ability to chew and swallow

- teeth - own/dentures
  - condition and adequacy

- swallowing - safe and adequate
  - requires modified food
  - requires special positioning

GENERAL APPEARANCE

Weight, height and overall appearance

HABITS

Sleep

Smoking

Alcohol/drug use

Sexual function

Exercise

ORIENTATION, MEMORY AND INSIGHT ASSESSMENT

Common items in memory measurement

Name

Age

Birthdate

Home address or present location

Location of assessment

Day

Date

Season

Time

Awareness of condition

Behaviours that pose a danger to self or others

Assessor's verification or comment on client's responses

CURRENT SERVICES/TREATMENTS

Medical/psychiatric history

Diagnosis

Medication (prescribed and over-the-counter)

Diet

Allergies

Frequency of medical supervision - physician
- laboratory

Nursing Care/Supervision

Rehabilitative Services
- Physiotherapy

- Occupational therapy

- Speech therapy

Special Services
- Inhalation therapy, oxygen therapy

- Radiotherapy

- Other

- Social services - specify

- Need for supervision/surveillance

SUMMARY STATEMENT OF THE PROBLEM

CLIENT/FAMILY EXPECTATIONS

APPENDIX II

CONTINUUM OF LONG-TERM CARE SERVICES

The following list illustrates a range of care/shelter services that are included in an appropriate continuum of long-term care. This is not an exhaustive list. The types and amounts of services will vary from province to province.

Home Care

The coordination and supply of essential services to assist recovery or maintain independent living. The structure and content of home care programs varies from province to province but generally includes homemaker services, meals on wheels, medical supplies and equipment.

Homemaker Services

Assistance given by trained personnel to persons requiring long-term help with basic living needs. May include general help around the house with cleaning, laundry, cooking and shopping and personal care.

Home Delivery of Meals - Meals on Wheels

Delivery of hot, nutritions meals to disabled persons at their place of residence.

Wheels to Meals

Transportation of disabled persons to a central location where they receive a nutritious meal and benefit from social interaction with staff and others.

Geriatric Assessment Unit

A specialized unit that focusses on assessment, diagnosis and initial treatment of elderly persons who require specialized attention. May be located in a hospital, in the community or as part of a day hospital. Often a team of specialists from the unit will go to the person's home.

Home Nursing Services

Skilled nursing procedures performed in the home to treat acute and chronic conditions, to assist convalescence and to monitor health status in chronic or palliative care situations.

Home Therapy Programs

For individuals unable to travel to outpatient services or when therapy is best delivered in the home where individuals are taught to adapt to their surroundings: physiotherapy, occupational therapy and speech therapy can be provided.

Equipment and Supplies

Provision of essential equipment required to maintain the person's health, e.g. medical gases, assisted breathing apparatus, and also improve the opportunities for self-care and a better quality of life, e.g. wheelchairs, walkers, electronic aids, etc. Equipment may be loaned, purchased or donated.

Adult Day Care

A group program to which individuals are transported on one or more days each week to receive health supervision, therapeutic care, a meal and social support.

Day Hospital

An ambulatory facility where the orientation is primarily therapeutic and where traditional health professionals and specialists are significantly involved.

Extra Mural Hospital

Available in New Brunswick, the extra-mural hospital brings services, similar to those provided by the day hospital, to a person's home, usually to facilitate early discharge from hospital. Entry to the service is by physician referral.

Transportation Services

Services provided to the disabled to allow them to go shopping, keep appointments and attend social functions. Many vehicles are adapted for wheelchairs and other devices.

Mental Health Services

Specialized care services; may be in the community or in units caring for individuals with severe mental and/or physical dysfunction. Such services are usually attached to hospitals or nursing homes.

Support Groups

Group initiated by many sources, e.g. community and institutional services, friends and families of clients, clients having similar disabilities. The groups provide psychological support and foster mutual aid.

Crisis Support

Mechanisms available in the community to give emergency assistance when existing arrangements break down, e.g. illness of the spouse caring for a disabled person, which could include emergency admission to institutional care.

Life and Social Skills for Independent Living

Training, retraining and support for independent living, and for social and personal development in group settings or on an individual basis.

Respite Services

Day, night or full-time temporary relief provided to primary caregivers by providing a substitute for the caregiver in the home or by providing alternate accommodation to the handicapped individual.

Palliative Care

Services provided to dying persons in their homes or in institutions.

Rehabilitation Services

Services aimed at restoring lost functioning or maintaining existing functional levels provided by health care professionals such as physiotherapists, physiatrists, occupational therapists, audiologists and speech pathologists.

Vocational Training and Rehabilitation

Assessment of potential and training and rehabilitation of disabled persons who are entering the work force, who must change careers due to the disability or who wish to learn new skills.

Volunteers

Organized programs of volunteer help that are utilized in most aspects of long-term care, includes long-term care recipients who volunteer their own services to others.

Congregate Living Facilities

Apartment complexes which offer amenities such as emergency response, social support and shared meals.

Group Home living

An alternative to institutional care, group homes allow a small number of individuals to live in a home-like setting where they perform tasks within their capabilities but are assisted by live-in staff who provide personal or medical care and who take care of domestic arrangements.

Residential Facilities

Facilities offering room and board but no skilled nursing care.

Nursing Home and Chronic Hospital Care

The delivery of Type 1, II or III facility Care.[14]

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14 As defined in The Report of the Working Party on Patient Care Classification to the Advisory Committee on Hospital Insurance and Diagnostic Services, November 1973.

ADMINISTRATIVE ORGANIZATION, POLICIES AND PROCEDURES

Guidelines for the administrative organization, policies and procedures for units/services/programs (hereinafter referred to as program(s) in hospitals) were formulated after a review of provincial, national and international information. It is hoped that the following outline will serve as a guide for the development of more comprehensive and specific program policies in order to ensure the most effective and efficient delivery of patient care in these programs.

I. ROLES AND OBJECTIVES

- Role and objectives of programs in hospitals

- Type of patient served
  - by diagnosis and/or severity of illness
  - restriction of service, if any (e.g. terminally ill patients)

- Components of program provided

II. ORGANIZATION OF PROGRAM

- Governing board responsibility

- Relationship to administrator and medical staff

- Service management

(i) Specific responsibilities of staff
  - Medical director
  - Other medical staff
  - Direct patient care staff
  - Other staff (administrative, technical and other)

(ii) Committees
  - Membership to be defined by discipline and number

- Terms of reference to be defined
- Provision for consultation with appropriate hospital and medical staff
- Schedules for formal and ad hoc meetings

III. POLICIES FOR OPERATION OF PROGRAM

1. General

- Admission authority (identification of individual(s) who have authority to admit)

- Admission priorities:
  - Clinical condition
  - Diagnostic category

- Discharge policies and planning

- Drug and procedure (new) approval process

- Emergency delegation of responsibility to medical, nursing and/or other staff

- Ethics processes

- Handling of emergency situations including C.P.R.

- Infection control and isolation

- Length of stay by diagnosis

- Medical orders

- Palliative care, determination of death, authorization for autopsies, handling of bodies

- Patient records, reports and charting

- Referral, consultation (mandatory and other), transfer, follow-up

- Research/clinical investigation

- Routine admission standing orders

- Utilization monitoring

2. Staff

- Criteria for granting medical/clinical privileges
- Delineation of student and supervisor roles including responsibility, authority and accountability
- Medical coverage/Staff coverage of service
- Orientation and continuing education
- Performance evaluation
- Position descriptions
- Selection criteria: education, experience, interests
- Volunteers

3. Patient

- Confidentiality
- Consent for treatment
- Family participation
- Patient/family education
- Patient's rights
- Patient valuables, assets and belongings
- Visiting privileges

4. Safety

- Equipment maintenance and safety
- Fire/disaster plans and associated isolation procedures
- Missing patient search procedures and risk identification

- Reporting of accidents and incidents

- Safety and accident prevention

- Use of restraints

5. Quality Assurance

- Audits: medical and nursing care, concurrent and retrospective

- Continuing evaluation of effectiveness of service

- Employee performance appraisal

- Incident reports

- Infection control

- Morbidity/mortality review

- Patient care review

- Patient status assessment on admission and discharge

- Peer review

- Practice standards

- Product and equipment use and evaluation

IV. PROCEDURES

1. Elective procedures: medical, nursing and other

2. Emergency alert system procedures

3. Medical record and statistical procedures

4. Policy and procedure manuals

GUIDELINES FOR INSTITUTIONAL PROGRAMS

The following guidelines have been prepared by the Federal-Provincial Subcommittee on Institutional Program Guidelines. These guidelines were requested by the Federal-Provincial Advisory Committee on Institutional and Medical Care Services. Some Guidelines previously published by the Subcommittee:

Addiction Services in Hospitals (1984)
Adult Long-Term Institutional Care (1984)
Adult Psychiatric Services Provided by General Hospitals (1979 under revision)
Assessment and Placement for Adult Long-Term Care: A Single-entry Model (1988)
Breast Imaging Services : Mammography (1986)
Burn Unit (1985)
Cardiovascular Services in Hospitals (1986)
Child and Adolescent Psychiatric Services Provided by General Hospitals (1980)
Child and Adolescent Services in General Hospitals (1982)
Child and Youth Longterm Services (1985)
Computed Tomography (1986)
Day Surgery Unit (1982)
Dental Care Units in Hospitals (1979 under revision)
Diabetic Day Care Unit (1978 to be revised in 1988)
Diagnostic Imaging Services and Systems: An Overview (1986)
Diagnostic Ultrasound Facilities in Hospitals (1985)
Emergency Services in Hospitals (1981 under revision)
End-Stage Renal Disease Program (1986)
Geriatric Day Hospitals - Geriatric Unit in a Hospital (1979)
Hospital Day Medicine (1984)
Intensive Care Unit (1986)
Magnetic Resonance Imaging (1986)
Nuclear Medicine in Hospitals (1985)
Organ and Tissue Donation Services in Hospitals (1986)
Palliative Care Services in Hospitals (1981, to be revised in 1988)
Patient Hostel Unit (1978)

Perinatal Intensive Care Units in a Perinatal Care Network (1986)
Pre-Hospital Emergency Services (1985)
Pulmonary Function Laboratories (1982)
Rehabilitation Medicine Program (1986)
Respiratory Therapy Service (1987)
Reuse of Disposables: An Information Report (1985)
Spinal Cord Injury Program (1986)
Stroke Program (1986)
Vital Organ Transplant Centres (1987)